DMAS Response to
CMS Formal Request for Additional Information on
Virginia's Section 1115 "Medicaid Buy-In Program" Demonstration Proposal

General

1. ***What is the demonstrable hypothesis being tested? What are the outcomes to be achieved and what is/are intervention(s) to be tested?***

   Response:

   The *main hypothesis* to be tested in this research and demonstration waiver program is that the provision of comprehensive employment supports or case management services to individuals with disabilities will enable them to maintain employment and increase earnings and assets. Given this hypothesis, the following outcomes are expected from the provision of individualized employment support services:

   - The earnings and assets of program enrollees will increase significantly over time.
   - The earnings increases among program enrollees will be significantly higher than the earnings increases of a matched comparison group.
   - The duration of enrollees' employment (i.e., the length of a given employment "spell") will increase significantly over time.
   - The duration of enrollees' employment will be significantly higher than the employment duration in a matched comparison group.

   The *secondary hypothesis* to be tested is that employment and the provision of employment supports coordination decreases the need for and utilization of medical and other health care services. Given this hypothesis, the following outcomes are expected from the employment experiences and the provision of individualized employment support services:

   - Enrollees' use of medical and other health care services will decline significantly over time.
   - Enrollees' use of medical and other health care services will be significantly lower than the standard Medicaid costs for the Blind and Disabled recipients in Virginia's Aged, Blind and Disabled covered group.

   Evaluation of the Main Hypothesis

   The intervention to be tested as part of the main hypothesis is coordination and provision of comprehensive employment supports. Specific activities associated with the coordination may include:

   - Linking the individual with appropriate community resources.
   - Coordinating services and treatment planning with other agencies and providers.

- Monitoring service delivery and quality of care.
- Assisting the recipient directly in developing or obtaining needed resources.

The array of organizations and support services that may be available through the program by referral include, but are not limited to:

- Local Benefits Planning, Assistance, and Outreach Program (BPAO) or other trained disability service personnel — work incentive and benefits planning;
- Local One Stop Center — job searches, skills assessment and training;
- Department of Rehabilitative Services (DRS) — vocational rehabilitation, personal assistance services, supported employment, brain injury services[1];
- Department for the Blind and Visually Impaired (DBVI) — vocational rehabilitation for the blind and visually impaired;
- Department for the Deaf and Hard of Hearing (DDHH) — services for the deaf and hard of hearing;
- Virginia Office for Protection and Advocacy (VOPA) — information and referral, technical assistance, advocacy and/or legal representation for consumers;
- Local Community Services Board (CSB) — mental health and substance abuse treatment; mental retardation services[1];
- Local Center for Independent Living (CIL) — independent living skills, peer counseling, individual advocacy, accessible housing referrals;
- Health care services covered through Medicaid, including personal assistance services in the home and at the workplace through the MBI program;
- Transportation assistance; and
- Housing assistance.

To determine the effect of this unique, comprehensive set of employment coordination and support services on employment and earnings outcomes, the research model will compare outcomes of the Medicaid Buy-In participants who received comprehensive employment support services ("program group") to the outcomes of a similar group of individuals who do not receive the employment support services ("comparison group").

It is expected that most of the individuals who enroll in the Buy-In program will receive comprehensive employment supports. Those enrollees who have earnings <u>below</u> the minimum employment target ($412 in 2004) will be required to access employment support services that the participant and his or her employment supports coordinator deem necessary as part of the individual's employment plan. Enrollees whose earnings <u>exceed</u> the minimum employment target will have a choice of whether to receive any or all of the services available through the program. These individuals who choose to avail themselves of these services also will have to work with a coordinator and establish an employment plan. Many

[1] A list of comprehensive employment supports from primary service agencies is located in APPENDIX I.

of these individuals who are not required to use the employment supports are expected to take advantage of the services offered, based on current experience with the state-funded Long Term Rehabilitation Case Management Program (LTRCM) operated by DRS. With the single exception of the LTRCM, no other existing DRS service model provides the intensive, employment-focused service coordination and supports that many individuals with disabilities need in order to maintain employment that substantially increases their earnings and independence. The LTRCM Program provides intensive case management and supports coordination for individuals with severe physical and sensory disabilities and it currently has a waiting list of 180 people who have been determined eligible for the program. Though this number includes only individuals with physical and sensory disabilities, it does indicate that there is a significant unmet need for such assistance.

The comparison group for this research project will be drawn from a dataset of individuals who applied for services to the Virginia Department of Rehabilitative Services (DRS) in a similar time period as the program group. The dataset maintained by DRS includes extensive information on individuals' employment history (including earnings, employment duration, and number of employers, both prior to and after their contact with DRS), personal characteristics, SSA status (i.e., whether they are receiving SSI, SSDI, both or neither), the services they have received through DRS, and the labor market conditions in the area in which they live. Program group members will be matched with persons in the DRS dataset to identify those with similar characteristics. This match will be done using all relevant variables, such as region, age, sex, education and employment background. By using a matching methodology to select the comparison group, the expectation is that the individuals in the program and comparison groups will have similar service needs, but receive very different services.

People in the comparison group may have access to employment-related services and supports, both through DRS and in the community. The DRS dataset includes information on the types of services provided to the comparison group by DRS, but the waiver evaluation team will not have access to complete information regarding services received from these other non-DRS community providers. Therefore, though the evaluation team may not be able to stipulate that the comparison group did not receive similar employment support services as the program group, the probability that any member of the comparison group received the type of comprehensive services offered to program members is very small because this high level of ongoing service coordination and supports is not generally available.

The data sources for the factors and outcomes being measured are listed in Table 1. As shown, data on employment duration and earnings for both the program and the comparison groups will be obtained from earnings records maintained by the Virginia Employment Commission (VEC). Much of the pre-program information for the program group will be collected from the initial interview. The instrument used in the initial interview will capture government benefits accessed, and demographic and employment data. The screening tool to be developed for this research and demonstration project may be adapted from other tools already in use with similar populations, but will likely be contracted out to an appropriate professional/university-based organization for development.

Table 1 Summary of Data Sources			
	Factor	**Program Group Data Source**	**Comparison Group Data Source**
Pre-Program Controlled Factors	Demographic Information	Initial interview using screening tool	DRS dataset
	Employment History	Initial interview using screening tool	DRS Dataset
	Earnings	VEC	VEC
Post Program Outcomes Measures	Employment Duration	VEC	VEC
	Earnings	VEC	VEC
	Assets	Initial and semi-annual interviews	N/A

Once the program and comparison group are identified and the various data are collected, the research team will compare pre- and post- program outcomes. Of particular interest will be outcomes related to earnings, assets, and duration o f employment.

Dr. David Dean, Director of the Bureau of Disability Economics Research at the University of Richmond,[2] has been identified as a potential research collaborator to assist with this evaluation. Dr. Dean has extensive experience in researching the employment experience of persons with disabilities and with working with DRS data. Several other university-based researchers with extensive experience in health services research, in addition to Dr. Dean, have also been identified as potential collaborators.

Evaluation of the Secondary Hypothesis

In addition to the earnings outcome data that will be examined to address the major hypotheses, the waiver project will examine factors that influence participants' employment and health care utilization outcomes. Data on participants' employment history and personal characteristics (e.g., age, race, gender, disability or disabilities, level of education) will be

[2] Dr. Dean is currently an associate professor of economics at the University of Richmond and Co-Director of the Bureau of Disability Economics Research (BDER). He has examined issues related to the economics of disability for the past 25 years. His work at BDER has concentrated on assessing the effectiveness of various federal and state return-to-work programs for persons with disabilities. Dr. Dean has participated in numerous funded research initiatives sponsored by the International Labor Organization, Rehabilitation International, U.S. Departments of Education, Labor, and Veterans' Affairs, Social Security Administration, and various state rehabilitation and workers' compensation agencies. In particular, he has performed evaluations of the efficacy of the federal/state Vocational Rehabilitation program, the Vocational Rehabilitation & Employment Service program for disabled veterans, Social Security Administration's Ticket-to-Work program, workers' compensation return-to-work programs, and both supported and sheltered employment programs. His evaluation work has been published in the *Journal of Human Resources, Journal of Policy Analysis and Management, Economic Education Review, Evaluation Review,* and *Contemporary Economic Policy* as well as various rehabilitation journals.

collected to examine the impact of these various factors on participants' levels of employment success and health care utilization. The demonstration project will track enrollees' utilization of employment supports and other services, in order to collect information regarding what types and intensity of assistance are needed for individuals with significant disabilities to succeed in reaching their employment goals.

The health care costs and utilization of the program group will be compared to that of the Blind and Disabled recipients (ages 18-64) in Virginia Medicaid's Aged, Blind and Disabled covered group. Outcomes for both groups will be evaluated to determine whether the program group experiences are consistent with or better than those of this similar Medicaid population.

2. ***Has the State contacted other buy-in states, either directly or through the technical assistance providers associated with the Medicaid Infrastructure Grants, to determine if information exists to address Virginia's specific concerns? Please provide details on the State's findings.***

Response: Virginia has been in regular contact with its technical assistance provider the American Public Human Services Association (APHSA) about work incentives that existing Medicaid Buy-In programs are providing to their recipients. APHSA technical advisor Allen Jensen recommended speaking with Oregon MBI representatives and reading the *Three State Work Incentives Initiative: Oregon, Vermont, and Wisconsin, Implementation Evaluation Report*[3]. The Oregon MBI incorporates some employment counseling and the report describes the design of the program. Mr. Jensen and his colleague Mark Newsome were not aware of any other MBI states that incorporated comprehensive employment support services.

The Oregon MBI program, Employed Persons with Disabilities (OEPD), used resources that were initially developed under the Oregon Employment Initiative (OEI), which was a 1996 directive from the director of the Oregon Department of Human Resources (DHR). This directive was specific to the DHR divisions and a coordinated effort to increase the employment of people with disabilities. Per "The History of the Employment Initiative" handout that was distributed in 1999, the purpose of the Employment Initiative was to "…help the individual assess his or her strengths and weaknesses, identify occupational goals, overcome barriers and achieve the desired level of employment." In order to design and implement a public-private collaborative program, the assembled workgroup received research funds from the Robert Wood Johnson Foundation (RWJF) and the Rehabilitation Services Administration (RSA). In 2001, the Oregon Department of Human Services received a Medicaid Infrastructure Grant and a Department of Labor Work Incentive Grant in addition to the RWIF and RSA grants which facilitated the creation of the Disability Employment Policy Unit (DEPU). Thus, the OEPD program is one component of a consolidated effort among Oregon government agencies using four revenue streams to increase employment for individuals with disabilities. More specifically, the OEPD would

[3] Hanes, Pamela, Christine Edlund, and Amy Maher. *3-State Work Incentives Initiative: Oregon, Vermont, and Wisconsin. Implementation Evaluation Report.* Report prepared for the Center for Health Care Strategies and the Robert Wood Johnson Foundation, May 2002.

guarantee health insurance through Medicaid to individuals who sought to increase their employment. The OEPD was then able to use these services to advance the employment of its Medicaid Buy-In participants.

As part of the OEI and OEPD implementation, the Senior and Disabled Services Division (SDSD) hired 19 Employment Initiative (EI) Specialists and back-filled nine VR counselors to provide employment supports and benefits counseling to people with disabilities. The EI Specialists were to serve as the primary outreach for MBI participants because they were very familiar with the OEPD program and other benefits and programs that benefit individuals with disabilities. The EI Specialist would be able to recommend the MBI option after providing benefits analysis and counseling. However, Oregon did not conduct a formal study to determine the use and effectiveness of this counseling. Oregon did conduct focus groups with OEPD consumers and these consumers "felt they did not receive adequate benefits counseling before enrolling in the program and would have liked a more thorough review of how the OEPD option in Medicaid was going to impact their Social Security benefits before enrolling."[4] Conversely, in a first year follow-up survey, the OEPD participants did not express a need for more time from caseworkers to answer questions and concerns about benefits. Other than the focus groups and the follow-up survey, there appear to be no other official Oregon inquiries into the effectiveness of the EI Specialist.

On March 10, 2004, Virginia MIG staff spoke with the APHSA's Center for Workers with Disabilities' Director, Mark Newsome, to further discuss the Oregon information and inquire whether Mr. Newsome knew of any states offering comprehensive employment supports as part of the their MBI plan. Mr. Newsome was not aware of any MBI plans that incorporated employment supports but he suggested that Virginia use the monthly national technical assistance conference call to inquire directly of the participating states. At the March 18, 2004, conference call, staff posed the question and received no affirmation of other states utilizing comprehensive employment supports as a component of their MBI program. Thus, Virginia is not aware of any other state that has intensive employment supports as part of its MBI plan.

3. ***Has the State determined if the proposed demonstration will be centered in Northern Virginia?***

Response: DMAS will establish the Medicaid Buy-In (MBI) waiver project in the pilot area of Northern Virginia. In considering this area, agency staff initiated discussions with several members of the OneSource Capacity Building Team, a project of the Northern Virginia Workforce Investment Board, regarding creating a new collaboration to support the education and outreach efforts in the pilot area. DMAS and OneSource recently completed a project through a partnership that developed training and educational modules on the SSI work incentive available through Section 1619(b) of the Social Security Act.[5] Some of the

[4] Ibid.

[5] *DMAS initiated a pilot project in Northern Virginia to identify and address the problems or misunderstandings associated with Medicaid eligibility and enrollment under 1619(b). With the cooperation of the Social Security Administration (SSA) and the Virginia Department of Social Services (DSS), the 1619(b) Pilot has focused on: (1)*

individuals who participated in the 1619(b) project were part of recent discussions about implementing the new MBI project and they expressed great interest in working on this groundbreaking program to further enhance the opportunity for employment by individuals with disabilities in Virginia. DMAS staff has been invited to address a larger group of potential partners in the Northern Virginia area, who generally provide or facilitate employment services for individuals with disabilities (i.e., residential, vocational, State VR, County MR, advocates). With the support and active participation of these organizations, DMAS anticipates rapid enrollment into the program upon implementation and well-coordinated service delivery as a result of their direct involvement.

What are the boundaries of the selected region?

Response: The project boundaries would mirror the configuration of the Northern Virginia Workforce Investment Board's coverage area. The pilot area, therefore, would include communities that are urban, suburban and rural: Fairfax County and the Cities of Fairfax and Falls Church, Loudoun County, Prince William County and the Cities of Manassas and Manassas Park. As was done with the 1619(b) project, Fauquier County, which is not within the Board's boundaries, will be included to further expand to the project's reach and insight of rural environments and the different challenges or barriers faced by residents therein.

If Northern Virginia is designated, what is the basis for limiting where participants may work given the proximity of Northern Virginia to DC and access to employment with the Federal and DC governments*?*

Response: Residency within the designated localities of the Commonwealth and paying Virginia income taxes are the only requirements, regardless of where an otherwise eligible person works. As described in the original waiver application (Program Infrastructure section, A. Target Population, page 14), DMAS chooses to limit waiver participation to one geographic region, such as Northern Virginia, because the number of participants will be relatively small (200) for a statewide rollout and the education/outreach will be quicker, less expensive and hopefully very effective if effort is concentrated in a smaller geographic area. The Northern Virginia area, for instance, currently has a well-developed network of providers, community services, advocacy groups, transportation, and communication systems that can efficiently implement a waiver demonstration project. As previously alluded to, because of a recent working relationship with a broadly based disability service and employment network, the collaborative nature exists to build upon and to promote and support the project in this limited setting.

What is the rationale for employment to be in a region?

Response: As described above, employment is not restricted to be within the selected region, but residency in one of the communities is. This approach will enable the partnering organizations to inform and assist residents of the specific communities that they serve within the Commonwealth.

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retraining and educating the Northern Virginia staffs of SSA and DSS offices; (2) training the benefits professionals and consumer advocates who assist individuals with disabilities; and (3) informing consumers of the work incentive.

4. ***Will the State transition to a state plan amendment Medicaid buy-in following the demonstration period?***

Response: Yes, there is an expectation that Virginia will transition the 1115 waiver into a state plan amendment after most, if not all, of the initial five-year demonstration period. However, DMAS must first answer questions about who will participate, how best to serve them, and what the costs and benefits to the individual and the State would be before there can be a definitive answer. Ultimately, the Virginia General Assembly will make the final decision on the establishment of the MBI as part of the State Plan and allocate the necessary funding to offer the program statewide, but that will be based on the relative success of the waiver to promote, sustain and increase employment for individuals with disabilities.

If so, please describe how this will be accomplished.

Response: It is anticipated that the waiver will be initially approved for five years. This period of time will allow Virginia to collect cost data, recipient information, and earnings data that are specific to Virginia. Because the waiver enrollment will be limited to 200 recipients, Virginia anticipates that full participation and data collection will commence immediately. This information will be comprehensive in its description of the program and provide a full listing of the program's cost components. Similarly, the waiver research will allow DMAS to document the effect of recipients' increased income on access to health services and government provided benefits.

Once Virginia has program specific data, DMAS will be able to better design and forecast the financing of a state plan amendment that creates a statewide MBI program. Upon General Assembly approval of a state plan amendment, DMAS will initiate a statewide education and outreach program drawing on the experience of the waiver program. The State will then begin accepting and processing applications for the MBI. Meanwhile, the waiver participants will not be affected by the rollout of the state plan amendment and will continue on the 1115 waiver until the statewide MBI is fully implemented. Upon this implementation, the waiver participants will be shifted to the MBI and will experience no break in service or benefit.

If the project is centered in urban Northern Virginia, how will rural factors be considered in the evaluation process if the State transitions from a specific region to statewideness?

Response: Please refer to the response to question #3 above concerning the urban and rural demographics of the Northern Virginia region.

The waiver research in Northern Virginia will provide information to design a statewide plan because it consists of rural and urban areas. Every waiver participant will be required to take part in semi-annual interviews so DMAS can gain information about each individual's challenges to increasing employment. These interviews will record, and quantify, all identified employment issues so that the waiver program can be flexible and provide different resources to current and new waiver participants. It is possible that there are specific challenges to maintaining employment that are different for urban versus rural areas.

Accessibility to services may differ substantially as may the means by which the program accomplishes getting the appropriate services to all who need them. The interview results will permit DMAS to tailor the employment and support services that best serve each individual in each area. This information will be very important when Virginia transitions the MBI to a State Plan amendment because this research will allow DMAS to design programs that are sensitive to differing needs identified in the urban and rural areas of the State. Virginia's General Assembly will also want this information to demonstrate that the plan will be responsive and beneficial to all citizens of the Commonwealth.

5. ***How will the project interface with already operational workforce programs such as "one stop," "Ticket to Work" Vocational Rehab, etc., to ensure cost effectiveness, control of duplication of effort and overall coordination?***

Response: The Virginia Department of Rehabilitative Services, which operates the state-federal vocational rehabilitation (VR) program for all individuals except those who are blind, is a partner in the development and implementation of Virginia's Section 1115 Waiver Research and Demonstration Proposal to establish a Medicaid Buy-In Program. The Virginia Department for the Blind and Vision Impaired, which operates the VR program for the blind, is also represented on the Medicaid Infrastructure Grant Advisory Committee, which provided substantial input into the development of the proposed Medicaid Buy-In program. As a result of several grant-funded initiatives in the geographic area selected for the waiver program, a collaborative group of organizations coalesced to focus on assisting individuals with disabilities gain/retain employment. This group includes the area One-Stop services agencies, private non-profit providers of employment support services, the VR agencies, and mental health services providers, among others. The Northern Virginia Workforce Investment Board oversees policy making for the One-Stop Centers in the region and was also a partner with DMAS in developing a work incentive education/communication pilot project to enhance use of the work incentive under Section 1619(b) of the Social Security Act. Representatives of all the major constituencies of the disability community that need to be involved in this effort are included in the Advisory Committee, which has been actively engaged in the development of a Medicaid Buy-In program and will be involved in overseeing the implementation of the program.

On an operational level, one of the major emphases of the comprehensive employment support services and case management components of the waiver will be ensuring that participants are connected to the services and supports they need in order to maintain or advance in employment. The intent is to maximize the use of existing programs, both public and private, to more effectively coordinate services across organizations, address identifiable gaps and facilitate customized employment supports. Only when participants' needs cannot be met through existing programs and resources will DRS and the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) expend new resources to accommodate unmet need for services (see answer to Question 23 below). The approach for support coordination and case management in the waiver program will be modeled after the state-funded Long-Term Rehabilitation Case Management Program operated by DRS, which assists individuals with severe physical and sensory disabilities to work and to prevent, eliminate or reduce economic and personal dependency.

6. ***Will the demonstration cover all disabilities and will participants be selected on a "first-come, first served" basis for participation?***

Response: Yes, the proposed research and demonstration waiver will enable any individual with a disability (as per the definition established by the Social Security Administration) who meets all other eligibility requirements to participate in the Medicaid Buy-In program. Individuals who are eligible will include anyone with SSI or SSDI status, or in the event an individual has not yet received a disability determination by SSA, the Department of Rehabilitative Services' Disability Determination Services unit will conduct an evaluation and issue a decision. This is a common practice conducted for the Medicaid program per a contractual agreement with DMAS. Enrollment in the program will be on a first come, first served basis until 200 participants have been enrolled.

If all disabilities are covered, what is the projected number of persons for each disability type and how will unique supports required by each disability type be addressed?

Response: Based on the experience of other State Medicaid Buy-In programs, it is expected that between 35-50 percent of the enrollees will have a mental illness. Beyond this, the majority of the remainder will likely have physical disabilities and a relatively small number (less than ten percent) will have cognitive disorders. There will be a wide array of employment support services available to participants and these will be provided directly by the States' human service agencies (e.g., VR, MH/MR) or through contractual arrangements with community disability service providers that assist the various disability populations (e.g., physical, MI, cognitive). Because of the limited number of participants in the program, each person will have the opportunity for an individual assessment of service needs. Participants with income below the minimum employment target will be required to have this assessment; it will be voluntary for those with incomes above, but they will be strongly encouraged to participate in an assessment to better understand what assistance is available to them.

How will the evaluation measure differences and similarities across the disability types regarding other identified measures?

Response: Beginning with the initial interview, data will be collected to enable the evaluation of many factors, which will include consideration of disability types. The importance of measuring differences and similarities across types is recognized by the MIG Advisory Committee and the MBI partnering agencies. As described in the response to question #8 below, the MIG project has already undertaken research on the incremental earnings and length of time for establishing the employment "tiers" (required for some low-income MBI participants). The findings thus far indicate there may be different expectations for these requirements based on whether participants are mentally ill, cognitively or physically disabled. It is understood that there will be different service needs by type of disability and that is why there will be employment supports coordinators who will refer to appropriate sources for services and will communicate or provide the necessary linkages that cross agency boundaries. Both DRS and DMHMRSAS are committed to the provision of individualized, comprehensive employment support services and case management as needed

by each participant to sustain and succeed in his or her employment goals. These efforts will include collecting data by applicant type and service need, evaluating intensity of services provided and the subsequent appraisal of failure and success rates associated with employment outcomes of the MBI participants. The evaluation process will be structured to ensure that outcome measures and comparisons within and across disability types are accomplished. As with the interview and evaluation (service need) instruments, a non-affiliated, experienced professional/organization will be contracted to develop this process.

7. ***How will DSS track whether individuals continue to remain eligible to participate in the project?***

Response: DSS will not deviate from its current eligibility re-determination process that, by contract, occurs on an annual basis. As is the current practice for Medicaid recipients in Virginia's Aged, Blind, and Disabled covered group, participants will be required to personally report changes in their income to DSS. As DSS receives these changes, DSS will re-evaluate the individual's eligibility in the waiver program. If the individual has a combined earned and unearned income above 175 percent of the Federal Poverty Level (minus applicable disregards) at the re-determination, DSS will inform the DMAS MBI administrator that the individual is no longer eligible for the program and proceed with the disenrollment.

How often will project representatives meet with participants to determine their employment progress and recalculate monthly buy-in premiums as earnings increase?

Response: All participants will have the ability to seek assistance from the employment supports coordinator at any time. Waiver participants who earn below the earnings minimum will be required to work with a comprehensive employment supports coordinator to utilize services that will enable them to increase their income to their personal income threshold. Some individuals who earn above the minimum income threshold may also seek these services because they want more opportunities or services to increase their income. Other individuals may need comprehensive employment services well after their participation in the program because of an illness relapse that limits their ability to work and reduces their income. The employment supports coordinator will then help the individual design a program that will increase his or her ability to work. These services will also assist people that participate in the waiver and lose their jobs so that they can quickly become re-employed and not risk losing their eligibility to remain in the waiver.

All waiver participants will be required to participate in an initial interview and semi-annual interviews. Thus, all participants will see a program interviewer at least twice a year at the semi-annual interviews. These semi-annual meetings will provide an opportunity to recalculate the premium and apply a new premium if the income is determined to be in a new income/premium range. There will not be a change in the premium if the participant's income has not increased into the next income range. If there is a change in the waiver participant's income, the program coordinator will also contact DSS to report the income change using a transmittal form specifically designed for the waiver program. (The waiver participant should have already notified DSS of the income change.) DSS will then conduct

a re-determination to confirm the participant's eligibility. If the participant has countable income above 175 percent of FPL, DSS will notify the DMAS MBI administrator that the individual no longer qualifies to participate in the program and the individual will no longer be allowed to participate in the program.

8. ***Is the State able to provide economic based data supporting earning tiers and minimum employment targets?***

Response: The tiered employment concept was initially discussed with Thomas Hamilton and other CMS staff on August 8, 2003, and as a result of the positive CMS feedback, DMAS staff further developed the idea. Preceding this conference call, our Medicaid Infrastructure Grant Advisory Committee and Technical Design Subcommittee had numerous discussions about eligibility criteria for a Medicaid Buy-In waiver program and eventually reached consensus that a minimum earnings requirement of approximately $400 (based on half-time employment earning minimum wage) would ensure that participants were serious about work and gaining greater independence through increased earnings. Subsequent discussions with the Advisory Committee regarding waiver parameters and research and demonstration considerations caused reevaluation of the amount of the minimum earnings requirement, which resulted in a decision to lower it and develop a process to assist low wage earners, or minimally employed workers, to increase their earnings over time through a structured process. This led to development of the "tiers" approach of establishing earnings expectations through an evaluation of each low wage earner's circumstances (e.g., type of work, work history, disability, personal goals).

Through an existing contract with Dr. David Dean, an economist and Director of the Bureau of Disability Economics Research (see related footnote on question #1, page 4), an evaluation of employment-based data is being conducted, which will provide the basis for setting the earnings tiers for individuals participating in the program. This research on the employment experiences of VR/post-VR clients (described in Response to question #1) will be an excellent source for establishing guidelines regarding the amount of increased earnings and the length of time that it will take for workers who enter the program with minimal earnings (at least $85/mo. required) to reach the minimum employment target ($412/mo. in 2004). Based on an initial report of findings (see APPENDIX II) from Dr. Dean, the following results provide an overview of what may be expected of eligible participants entering the waiver program.

- Of those workers who had earnings of at least $255 ($85/mo. for 3 mo.) in the quarter in which they applied for VR (3,172 cases - Table 1, APPENDIX II), ten percent never reached the minimum employment target during the evaluation period, consisting of this application quarter and the 12 subsequent quarters.

- Of those workers who had earnings of at least $255 in the quarter in which they applied for VR and who reached or exceeded the minimum employment target within three years (2,840 cases – Table 4, APPENDIX II):
  - Nearly 64 percent did so during the quarter of application;
  - 79 percent had within two quarters;

- 85 percent had within three quarters;
- Over 89 percent by the fourth quarter; and
- The remaining 11 percent reached the target between one and three years following the quarter of application.

This brief initial examination of the data provides a perspective of what the overall experience may be for the proposed MBI program. While it is hoped that all participants will exceed the minimum employment target, there may be participants who will be unable to reach this target. A goal of the program is to minimize the number of imperfect outcomes by helping participants in reaching their goals by providing access to employment support services with the direct assistance of a coordinator to ensure participants get what they need to succeed. It is expected that some enrollees will enter the program with earnings that exceed the target, but for those that do not, research indicates that most will complete their tiered employment requirement in a year or less, while a small number will need significantly more time to reach the target.

The report also includes several tables that explore various cohorts to establish more disease-specific guidance (e.g., mental illness, cognitive and physical disabilities). The tables examine the progression of earnings for: 1) anyone who attained the minimal earnings of $255 sometime during the 13-quarter evaluation period; and 2) the subset of only those persons who reached $255, but not the minimum employment target, during these 13 quarters. Dr. Dean has prepared many additional tables illustrating the amount and progression of earnings over the course of 13 quarters for numerous groupings of the VR/post-VR clients included in the study. DMAS and its partner agencies will continue to work with Dr. Dean in examining these data in the months ahead so that the employment supports coordinator will have a well thought-out basis for establishing the "tiers" for each individual who is evaluated for support services because his or her income is below the target.

DMAS will forward the above referenced additional tables (48) to CMS upon request. DMAS also will advise CMS accordingly of future developments in this regard.

To what degree will the State enforce the tiered income targets requiring individuals to increase his/her earnings or lose Medicaid benefits?

Response: DMAS will not automatically terminate participants from the MBI program simply for failing to reach a designated tier within the individually determined time frame. These predetermined earnings increases and time frames will be established for each individual based on the unique circumstances of each worker, including the type of work, employment status (e.g., part-time, self employed, piece meal work, on-call/as needed), limitations of the disability, employer limits on work/hours, illness, or loss of job. The individual's employment supports coordinator will review all mitigating factors that impact the individual and the work environment when evaluating why the person was unable to reach his or her goal/tier, as well as the basis for originally establishing said goal.

Discussion with the MBI participant may lead to revision of the original tiers (size of increase and/or length of time to reach) and reassessment of the employment supports needed to continue advancement toward the minimum employment target. This evaluation may also lead to the conclusion that the individual is unable to advance further and has reached his or her maximum employment potential. In either case, the employment supports coordinator will continue to offer assistance and not terminate the individual from the program. It is expected that there will be failures in reaching the minimum employment target but striving to reach one's potential and highest level of independence are paramount to the program. It is further expected that termination from the program would only be predicated upon the individual's inability to return to work or refusal to cooperate with yet-to-be established protocols that each participant will agree to in writing at the time of enrollment into the program. Coverage will be continued for an individual who is not able to return to work for a period of up to six months. In the case of an uncooperative participant, the employment supports coordinator would encourage continued participation as agreed to at enrollment and engage other resources in an effort to forego termination from the program. Persistent failure to cooperate will cause notice of termination to be issued to the individual. In either case, a determination of eligibility for other Medicaid categories will be conducted in order to enable a smooth transition and no break in Medicaid coverage, should the individual be determined eligible.

Is there a minimum hour requirement that will be imposed?

Response: No, there will not be a minimum hour requirement, but there is a minimum earnings requirement of $85 per month to be eligible to enroll in the MBI program. The minimum employment target of $412 per month (in 2004) is based on working 20 hours per week at minimum wage, but it will not be the number hours that will be considered, just the amount of income earned.

9. ***What is meant by "self-employment"?***

Response: Self-employment may be defined as the operation of a trade or business by an individual or by a partnership in which an individual is a member.[6] In explaining self-employment income and self-employment, the Internal Revenue Service includes the following description: "A business is a continuous, regular activity that has income or profit as its primary purpose. Independent contractors are self-employed. Self-employed workers control the method and means of performing services for others. In contrast, employers direct or control the work of their employees."[7] In determining whether an activity constitutes self-employment, Virginia Medicaid eligibility determinations follow SSI procedure wherein all factors in a case are considered when an individual alleges participating in an activity that produces income to determine if it constitutes self-employment. The same process will be used in determinations for eligibility for the Medicaid Buy-In waiver. According to SSI policy and included in the Virginia Medicaid eligibility manual for the Aged, Blind, and Disabled covered group, self-employment is the Net Earnings from Self-Employment (NESE), which is the gross income from any trade or

[6] http://www.cms.hhs.gov/glossary/search.asp?Term=self-employment&Language=English&SubmitTermSrch=Search
[7] http://www.irs.gov/app/understanding Taxes/servlet/IM12rp

business less allowable deductions for that trade or business. NESE also includes any profit or loss in a partnership[8].

Applicants to the waiver program may prove self-employment income by furnishing DSS with their last Federal Income Tax return and any necessary schedules, such as Schedule C, C-EZ, or F. If the individual did not file his/her last Federal Income Tax return as a self-employed individual, that individual will have to furnish his/her business records — income and expenses — to prove self-employment. Additional proof of self-employment can include a business license, if applicable.

DSS eligibility workers will apply the standard SSI deductions along with Blind Work Expenses (BWE) or Impairment Related Work Expenses (IRWE) to this income to determine the NESE. This adjusted figure will then be used to determine if the individual has earned and unearned income below 175 percent of the Federal Poverty Level. The individual will be allowed to participate in the waiver if the annualized gross income minus disability-related deductions is below 175 percent of FPL and there is an available slot.

Public Process

10. ***Who are the members of the Advisory Committee and two subcommittees that have provided input into the proposed demonstration? What is the number of agency representatives and advocate representatives?***

Response: The MIG Advisory Committee currently has 43 members and represents all of the major constituencies involved in development of Virginia's Medicaid Buy-In program. Nine of these individuals represent various state disability services agencies including:

- Virginia Office for Protection and Advocacy,
- Virginia Board for People with Disabilities,
- Department of Rehabilitative Services,
- Department for the Blind and Vision Impaired,
- Department of Mental Health, Mental Retardation and Substance Abuse Services,
- Department of Deaf and Hard of Hearing, and
- Department of Medical Assistance Services.

Fourteen members represent various advocacy organizations including:

- ARC of Virginia,
- Virginia Alliance for the Mentally Ill,
- Virginia Association for the DeafBlind,
- Autism Program of Virginia,
- Virginia Association for the Blind, and
- Spinal Cord Injury Council.

[8] From the Virginia Medicaid eligibility manual for the Aged, Blind, and Disabled (ABD) covered Group income determination at the Virginia Department of Social Services. Volume XIII, S0820.200. page 19.

Several Centers for Independent Living have representatives and another four members are consumer advocates. Eleven members represent various state and local service providers, including several community rehabilitation programs, mental health, mental retardation, and brain injury services providers, and the HIV/AIDS Center at Virginia Commonwealth University. The remaining members represent various other constituencies, including employers, university-based training and technical assistance centers. Approximately 20 Committee members are individuals with disabilities or family members of individuals with disabilities. A current list of the MIG Advisory Committee/subcommittee membership (APPENDIX III) is attached at the end of this document.

Can a member serve on more than one committee?

Response: MIG Advisory Committee members have been assigned to subcommittees to maximize cross-disability representation on each subcommittee. The two subcommittees that have been involved in development of Virginia's 1115 waiver proposal are the Technical Design (18 members) and Coordination of Services (10 members) subcommittees. At their own choice, a number of members do serve on more than one subcommittee. A third subcommittee focusing on education and communication strategies had previously developed a comprehensive strategy for community outreach and education for the MBI program during the first year of the project. These individuals also have had opportunity to provide input on the waiver proposal as part of the full Committee.

Eligibility

11. ***How does this proposal interact with SSI benefits?***

Response: The enhanced Medicaid benefits available through the MBI waiver program would replace any Virginia Medicaid coverage in existence since State/Federal regulations do not permit coverage under more than one eligibility category. Continuation of any cash benefits through the Social Security Administration would be dependent upon continuing to meet all other SSI criteria. In order to ensure that potential enrollees are aware of implications that may result from participating in the MBI, all applicants will be advised of the importance of meeting with a benefits advisor (e.g., regional BPAO). This will be strongly recommended during the initial required interview that will take place during the eligibility determination process. The proposed MBI has higher allowances ($7,500 individual, spouse not counted) than many other government programs (e.g., SSI = $2,000 one person, $3,000 two people), which could endanger loss of other benefits so this is an important part of the proposed program.

Is the population to be served under the demonstration different for the SSI population already covered as a mandatory coverage group?

Response: The proposed project will offer individuals who receive Medicaid coverage because of SSI eligibility the option of enrolling in the MBI waiver to earn higher income per annum than is allowable under SSI, which for Virginia is $24,055 in 2004 under Section

1619(b). A greater incentive for SSI beneficiaries, however, may be the opportunity to save well beyond the $2,000 individual limit historically allowed by SSI.

SSDI beneficiaries will also be eligible for MBI coverage as a result of their predetermined disability, if they meet all other eligibility criteria (i.e., unearned income limit, minimum earnings requirement, resource limit). In fact, any individual may participate in the MBI waiver program if he or she meets the income requirements and has been determined to have a significant disability, as defined by SSA, and established through the SSA disability determination process or through evaluation by the Disability Determination Services division of the Virginia Department of Rehabilitative Services, as is commonly done in pre-SSA situations.

Is the demonstration open to individuals not currently enrolled in Medicaid?

Response: Yes, participation in the MBI waiver is not contingent upon current Medicaid enrollment but is open to any individual with a disability who meets the MBI eligibility criteria referenced above. The criteria are intended to attract individuals who receive low disability income benefits, including current Medicaid enrollees in Virginia's optional Aged, Blind and Disabled group (allowable income up to 80 percent of FPL).

Clearly define the population to be served under the demonstration.

Response: As described above, the potential population for participation in the MBI waiver program includes all Ticket to Work recipients in Virginia, which totaled 220,442 as of March 3, 2004[9], and all other working age individuals who have a disability and meet the referenced eligibility criteria (see additional explanations in above Responses for question #11). All SSI and SSDI beneficiaries who have been deemed disabled by SSA are potentially eligible and there will be no exclusions due to type of disability. Participation will be limited to 200 workers with disabilities, as established by the legislature. In trying to further define the population to be served, data are typically available only on a statewide basis and not by locality, which limits the ability to accurately identify specific numbers of potential participants in the region proposed for the research and demonstration project. The data show:

- Virginia had 16,433 workers between the ages of 18-64 who were receiving both SSI and Social Security disability benefits on the basis of disability in December 2002.[10]
- Virginia had 133,540 disabled workers receiving OASDI benefits in December 2001.[11]
- Virginia had 108,974 blind and disabled SSI recipients in 2001.[12]
  - Reduced by 19,793 blind and disabled SSI recipients under age 18 in 2001,[13] there were 89,181 potential workers (includes age 65+) on SSI in the state.

[9] SSA/Ticket to Work program data at http://www.ssa.gov/work/Ticket/ticket_info.html
[10] SSI Annual Statistical Report, 2002, Table 18, page 39
[11] Social Security Bulletin, Annual Statistical Supplement, 2002, Table 5.J2, page 233
[12] Social Security Bulletin, Annual Statistical Supplement, 2002, Table 7.B1, page 282
[13] Social Security Bulletin, Annual Statistical Supplement, 2002, Table 7.B8, page 286

- There were 303 Section 1619(a) participants, 1,646 Section 1619(b) participants and 4,561 other blind and disabled SSI recipients who worked in December 2002.[14]
  - Recently received data indicate that as of 12/31/2003, there were 76,550 SSI beneficiaries between the ages 18-64 in Virginia; 314 Section 1619(a) participants, 1,419 Section 1619(b) participants and 4,421 other blind and disabled SSI recipients with earned income.[15]

Locality specific information regarding individuals with disabilities is available from the U.S. Census Bureau[16] as follows:

Table 2
Population to be Served in Demonstration Area

DISABILITY STATUS OF CIVILIAN NONINSTITUTIONALIZED POPULATION	Region	Fairfax City	Fairfax County	Alexandria City	Falls Church City	Manassas City	Manassas Park City	Prince William County	Fauquier County	Loudoun County
Total Population	1,740,053	21,674	985,161	128,773	10,612	35,814	10,589	298,707	57,820	190,903
	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Population 5 to 20 years	360,790	3,852	205,610	16,234	1,953	8,784	2,522	71,079	12,873	37,883
	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
With a disability	24,917	352	14,535	1,405	180	772	161	4,498	922	2,092
	6.9%	9.1%	7.1%	8.7%	9.2%	8.8%	6.4%	6.3%	7.2%	5.5%
Population 21 to 64 years	1,043,914	13,497	603,973	90,216	6,481	20,624	6,237	164,893	32,682	105,311
	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
With a disability	126,545	1,837	70,426	12,084	627	3,011	1,087	22,313	4,259	10,901
	12.1%	13.6%	11.7%	13.4%	9.7%	14.6%	17.4%	13.5%	13.0%	10.4%
Percent employed	70.1%	67.0%	70.8%	65.9%	68.6%	67.8%	73.7%	69.0%	63.4%	74.2%
No disability	917,369	11,660	533,547	78,132	5,854	17,613	5,150	142,580	28,423	94,410
	87.9%	86.4%	88.3%	88.6%	90.3%	85.4%	82.6%	86.5%	87.0%	89.6%
Percent employed	82.3%	83.4%	81.7%	83.0%	86.0%	82.8%	82.1%	82.8%	81.7%	83.8%

12. ***Will individuals who reside outside the demonstration area, but work within the project area, be allowed to participate in the proposed demonstration?***

Response: No, working individuals with disabilities who reside outside of the demonstration area but work within the area will not be permitted to participate in the MBI waiver project. First and foremost, potential participants must be a resident of the Commonwealth of Virginia in order to be eligible for the State's Medicaid program as well as the MBI. Waiver participation will be restricted to residents of the designated area of the demonstration project so that training and outreach can be focused and yield maximized. For MBI access to be

[14] SSI Annual Statistical Report, 2002, Table 32, page 63
[15] Source: SSI Work Incentive File and Revised Management Information Counts System (REMICS). Special data runs prepared for CMS (Stephen Knapp) by the Social Security Administration
[16] Source: Quick Facts from the U.S. Census Bureau, http://quickfacts.census.gov/qfd/index.html

allowed for Virginians outside of the demonstration area, training would have to be conducted at many more of the 121 offices of the Department of Social Services (DSS) where eligibility is determined, since DSS offices are locality-specific and only process applications from residents of the designated locale. Other service organizations that may also be involved and require education on the project/process could be restricted to serving only residents of specific localities as well. Again, allowing people who reside outside of the demonstration area to participate would expand the task of communication/education and in effect, expand the demonstration area. Please see earlier discussion under question #3 regarding probable demonstration area.

Program Infrastructure

13. ***Has the State considered the following: a) a hardship determination for waiver of premiums for enrollees who cannot work continuously due to disability; b) lower premium incentives for enrollees who increase their earnings within the allotted timeframe?***

Response: The Advisory Committee's subgroup on technical design of the MBI program did consider the question of allowing (a) a hardship determination to waive premiums for enrollees who are temporarily out of work. The group decided that the premiums were not sufficiently high as to pose a significant hardship upon non-working participants. (Minimum premium initially set at $25/month; increased to $35 with this document.) Though there was some sentiment to allow a period of arrearage in this circumstance, the administration of a premium collection process can become more labor intensive and, thus, expensive with the inclusion of additional factors such as hardship determinations. Past experience in Virginia has demonstrated that very low premiums and administrative complexities can cause the process to cost more than the amount of premiums collected. Offering (b) lower premiums as an incentive for enrollees to increase their earnings within the allotted timeframe was not an option that was considered by the technical design subcommittee. DMAS will revisit the (a) hardship determination and also consider the (b) lower premium incentive with the Advisory Committee if CMS determines that the stated position on either or both of these issues are impediments to approval of the waiver.

14. ***Will the State offer employer training to address confidentiality requirements and provide education on the unique needs of persons with disabilities?***

Response: In implementing the employment supports component of the MBI waiver program, employers will only be contacted by program staff with the explicit permission of the program participant. Existing policies and procedures of the agencies that are providing supports and services to participants will govern decisions regarding employer contacts and confidentiality requirements.

An employer outreach initiative designed to inform employers about the opportunities and challenges in employing individuals with disabilities is part of the existing MIG activities. This initiative has been developed in collaboration with the Virginia Business Leadership

Network[17] and the Department of Rehabilitative Services. Together with the One-Stops and other partners, DRS also has established regional workforce networks for coordinating employment activities among members of the workforce development system. These networks serve as a mechanism for educating employers about the needs of people with disabilities, as well a mechanism for identifying employment opportunities for jobseekers with disabilities.

15. ***What is the process for staff training to ensure standardization of the interview process? How will employee training needs be met and are there linkages with State supporting vocational rehabilitation programs?***

Response: Virginia will contract with a company that specializes in designing and facilitating interviews to develop the interview tool and to provide the training on the tool to the interviewers, who may be agency staff or contractual staff (i.e., employment services organization). As a part of the contract, the company will ensure that this staff is trained to collect the same information for every recipient through an unbiased process. The contracted company will maintain training standards by periodic evaluation of the interviewers and processes throughout the life of the contract. The training, evaluation, and follow-up protocols will be established prior to a finalized contract. DMAS will work with the Virginia Department of Rehabilitative Services (DRS) and other partner agencies to ensure that all training is in accordance with best practices and State standards.

How will employee training needs be met and are there linkages with State supporting vocational rehabilitation programs?

Response: The Virginia Department of Rehabilitative Services (DRS) will provide general literature to the interviewers to supply to the recipients but it will not be the interviewers' responsibility to educate recipients about vocational rehabilitation programs. The interviewer will collect information according to the standardized interview tool and then will refer recipients, as necessary, to the employment supports coordinator. All waiver participants who have earnings below the minimum employment target ($412/month in 2004) will be required to work with an employment supports coordinator as a participation requirement.

The employment supports coordinator will be knowledgeable of all vocational rehabilitation programs available for recipients and will refer recipients to the appropriate benefit, employment assistance, and case management services. As stated in the response to question #5, the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS), the Department for the Blind and Vision Impaired (DBVI), and

[17] The Virginia Business Leadership Network (VABLN) is a nonprofit, business-led group focused on increasing workforce and marketplace diversity by including people with disabilities. VABLN is part of a national program that engages the leadership and participation of companies throughout the United States to hire qualified job candidates with disabilities. Through this program, business leaders promote recruitment and hiring practices, enabling qualified people with disabilities to succeed in the workplace. In addition, these efforts promote marketplace diversity by tailoring services and access options for people with disabilities.

DRS are participating in the development and subsequent implementation of a Medicaid Buy-In program. These agencies currently have staff that provide services to the target population and will provide services to the MBI recipients. Each agency has training standards and protocols that will continue. Any private company that provides employment supports will be required to abide by these same training standards and protocols. If a private company is contracted to provide services, the state agency that provides similar services will ensure that the private company maintains the same standards and training accordingly.

16. ***Who is responsible for making the determination that a participant has reached his/her maximum employment potential due to a medical condition and what factors would be considered in making that determination?***

Response: An employment supports coordinator will work with each individual who is required to participate in tiered employment due to earning less income than the minimum employment target. These staff will be experienced disability services professionals (e.g., VR counselor, disability resource specialist, vocational evaluator) with specific training on the evaluation instrument. A determination that an individual has reached his or her maximum employment potential may be made by the employment supports coordinator after consultation with the individual and the service providers, as well as the individual's physician or other health care practitioner, if appropriate. A participant who reaches his or her maximum employment potential before meeting the minimum employment target will not impact the individual's eligibility to continue participating in the Medicaid Buy-In waiver, nor will he or she become ineligible for continuation of employment support services; however, these may be terminated if they become unnecessary to sustaining employment. In other words, a participant who is unable to reach an earnings level of $412 per month (in 2004) will not be terminated for failing to reach the target. Continuation of employment supports may be less necessary except to the extent they help the individual maintain employment.

The specific factors have not yet been established that will be considered in making the determination that an individual's maximum employment potential has been reached. The evaluation instruments will be developed with input from the rehabilitation specialists at the state Department of Rehabilitative Services and other appropriate state agencies, but it is expected that development of this tool will be contracted to a university or other professional organization with specific knowledge and expertise in the areas of employment and disabilities. As has been previously referenced, the individual's disability, limitations caused by disability, recurring illness/co-morbidities and type of work are among many factors that could influence the individual's employment potential.

17. ***How will the project address language needs of non-English speaking enrollees?***

Response: As stated in the original waiver application, DMAS endorses the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds. DMAS ensures that documents for recipients in its programs, such as the Medicaid enrollee handbook, are comprehensive yet written to comply with readability requirements. Program information

documents typically have a Flesch total readability score of forty (40) or better (at or below a 12th grade educational level). Additionally, written recipient material is available in alternative formats that takes into consideration the special needs of individuals with disabilities (i.e., visually limited) [42CFR438.10(d)(1)(ii)]. In addition, TTY/TDD services are available for the hearing impaired.

The proposed Medicaid Buy-In program will utilize the same methods of addressing language needs of non-English speaking enrollees as it does for its Medallion PCCM program and fee-for-service enrollees. Translation services are generally available through the AT&T Language Line Services to ensure effective communication regarding eligibility. As with Virginia Medicaid's managed care programs, MBI program communications will be made available in languages other than English when five percent of the Medicaid enrolled population in a geographic area is non-English speaking and speak a common language. Applications/outreach materials will be prepared in Spanish as well as English at the outset, though DMAS will confer with the collaborating organizations in the Northern Virginia target area regarding whether additional specific languages should be included in advance of program implementation.

Benefits

18. ***The State projects that 6 percent of the waiver population will use personal assistance services (PAS) based on the same methodology for determining PAS as it is used in its HCBS waivers. What is the amount of PAS required by people who are under the HCBS waivers and competitively employed?***

Response: In 2003, the Virginia MIG staff commissioned the Virginia Commonwealth University (VCU) Survey and Evaluation Research Laboratory (SERL) to survey all participants in Virginia's HCBS waivers who used PAS in fiscal year 2003 and who were between the ages of 18 and 64. Per the survey, less than two percent of waiver participants between the ages of 18 and 64 were competitively employed. Among those individuals that were using PAS in the workplace, the majority reported that they received between six and eight hours of PAS a day and most reported that they received PAS five days a week.

The report, *Personal Assistance Services Survey: Report of Findings, February 2004*, was submitted to Steven Knapp (Division of Community Systems Improvement, Disabled and Adult Health Programs Group, CMS) on March 18, 2004 as PAS SURVEY REPORT FINAL.pdf. Please refer to Mr. Knapp for a copy of the report.

Data Collection

19. ***Please provide an explanation of how Virginia will use administrative data sources and meet the data reporting requirements of buy-in states with MIGs.***

Response: Virginia will report any administrative data that is applicable to the MIG MBI reporting requirements. These reports will consist of MMIS queries and other ancillary data

that will include new enrollment, continuity in the program, disenrollment and reenrollment, fourth-quarter participation, general changes to waiver group over time, past Medicaid participation, enrollment in SSI and SSDI, use of third-party insurance, premium rates, earnings, changes in earnings, loss of government supplied benefits, and Medicaid expenditures. This information should fulfill any CMS MBI requirements, but will be modified as necessary to capture all data elements needed by CMS.

A major component of the proposed 1115 waiver is the requirement that all individuals submit to an initial interview and to successive interviews every six months. The purpose of these interviews will be to answer specific, pre-determined questions about employment, health and medical services utilization, the need and use of comprehensive employment supports, earnings, and the loss of government supplied benefits. Any CMS data requirement that is not fulfilled with the MMIS queries will be provided through the interviews or other data collection sources, such as employment supports coordinators records. Virginia will implement changes to its collection of MMIS data once the State transitions to a Medicaid Buy-In State Plan amendment. Data collected during the interviews will be maintained in an Access database to allow Virginia to create various reports.

20. ***Has the State analyzed employment opportunities in the proposed demonstration area and the availability of health care benefits for the targeted population? Please describe the employment opportunities for people with disabilities.***

Response: The State has not previously analyzed employment opportunities for people with disabilities in the proposed demonstration area. Information on the local economies in the proposed demonstration area was obtained from the U.S. Census Bureau (below). The more typical occupations that would be available to potential MBI participants will be management or professional positions, followed by sales and office, and then service positions. A variety of industries appear to share these types of employment opportunities, as shown in the following table.[18]

[18] Source: Quick Facts from the U.S. Census Bureau, http://quickfacts.census.gov/qfd/index.html

Table 3
Employment and Industry in Demonstration Area

	Region	Fairfax City	Fairfax County	Alexandria City	Falls Church City	Manassas City	Manassas Park City	Prince William County	Fauquier County	Loudoun County
Employed civilian population, 16 years & over	**907,142**	**11,924**	**522,398**	**76,584**	**5,857**	**18,238**	**5,513**	**144,748**	**28,622**	**93,258**
	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
OCCUPATION										
Management, professional, and related occupations	472,563	5,963	291,026	43,053	3,837	7,019	1,683	59,556	11,301	49,125
	52.0%	50.0%	55.7%	56.2%	65.5%	38.5%	30.5%	41.1%	39.5%	52.7%
Service occupations	106,989	1,743	59,099	9,132	596	2,532	791	19,530	3,714	9,852
	11.8%	14.6%	11.3%	11.9%	10.2%	13.9%	14.3%	13.5%	13.0%	10.6%
Sales and office occupations	216,315	2,726	119,441	16,253	1,055	4,949	1,406	40,216	7,260	23,009
	23.8%	22.9%	22.9%	21.2%	18.0%	27.1%	25.5%	27.8%	25.4%	24.7%
Farming, fishing, and forestry occupations	1,243	11	353	49	0	16	0	186	375	253
	0.1%	0.1%	0.1%	.01%	0.0%	0.1%	0.0%	0.1%	1.3%	0.3%
Construction, extraction, and maintenance occupations	60,715	824	28,285	4,135	168	2,202	1,034	14,825	3,598	5,644
	6.7%	6.9%	5.4%	5.4%	2.9%	12.1%	18.8%	10.2%	12.6%	6.1%
Production, transportation, and material moving occupations	49,317	657	24,194	3,962	201	1,520	599	10,435	2,374	5,375
	5.4%	5.5%	4.6%	5.2%	3.4%	8.3%	10.9%	7.2%	8.3%	5.8%
INDUSTRY										
Agriculture, forestry, fishing and hunting, and mining	3,759	49	1,103	119	11	44	11	458	1,147	817
	0.4%	0.4%	0.2%	0.2%	0.2%	0.2%	0.2%	0.3%	4.0%	0.9%
Construction	58,253	908	28,390	3,840	181	2,109	948	12,849	3,294	5,734
	6.4%	7.6%	5.4%	5.0%	3.1%	11.6%	17.2%	8.9%	11.5%	6.1%
Manufacturing	37,150	391	18,836	2,188	122	1,164	207	6,860	1,791	5,591
	4.1%	3.3%	3.6%	2.9%	2.1%	6.4%	3.8%	4.7%	6.3%	6.0%
Wholesale trade	17,166	202	8,857	1,214	83	375	155	3,121	965	2,194
	1.9%	1.7%	1.7%	1.6%	1.4%	2.1%	2.8%	2.2%	3.4%	2.4%
Retail trade	86,911	998	47,159	5,469	420	2,243	754	17,410	3,174	9,284
	9.6%	8.4%	9.0%	7.1%	7.2%	12.3%	13.7%	12.0%	11.1%	10.0%
Transportation and warehousing, and utilities	39,060	411	19,248	3,115	169	984	353	8,036	1,405	5,339
	4.3%	3.4%	3.7%	4.1%	2.9%	5.4%	6.4%	5.6%	4.9%	5.7%
Information	62,956	718	36,721	5,312	398	1,029	320	7,372	1,546	9,540
	6.9%	6.0%	7.0%	6.9%	6.8%	5.6%	5.8%	5.1%	5.4%	10.2%
Finance, insurance, real estate, and rental and leasing	62,316	927	37,350	5,423	400	950	364	8,196	1,981	6,725
	6.9%	7.8%	7.1%	7.1%	6.8%	5.2%	6.6%	5.7%	6.9%	7.2%
Professional, scientific, management, administrative, waste management services	179,461	2,343	112,036	16,862	1,193	2,656	676	22,083	3,591	18,021
	19.8%	19.6%	21.4%	22.0%	20.4%	14.6%	12.3%	15.3%	12.5%	19.3%
Educational, health and social services	132,666	1,998	76,883	9,882	905	2,806	800	22,473	4,525	12,394
	14.6%	16.8%	14.7%	12.9%	15.5%	15.4%	14.5%	15.5%	15.8%	13.3%
Arts, entertainment, recreation, accommodation, food services	61,027	1,087	36,413	5,640	355	1,364	272	9,012	1,563	5,321
	6.7%	9.1%	7.0%	7.4%	6.1%	7.5%	4.9%	6.2%	5.5%	5.7%
Other services (except public administration)	56,681	668	33,783	6,617	565	954	331	7,780	1,453	4,530
	6.2%	5.6%	6.5%	8.6%	9.6%	5.2%	6.0%	5.4%	5.1%	4.9%
Public administration	109,737	1,224	65,619	10,903	1,055	1,560	322	19,098	2,188	7,768
	12.0%	10.3%	12.6%	14.2%	18.0%	8.6%	5.8%	13.2%	7.6%	8.3%

The availability of employer-sponsored health care benefits for the target population is unknown at this time, but the information illustrated in the above table is indicative of the likelihood that this health care benefit will be available for the MBI population. It is

common practice in many of the occupations and industries that constitute the more significant employment opportunities above to offer health care coverage as one of their employee benefits in a competitive marketplace. In that Northern Virginia has a tighter labor market (i.e., low unemployment rate) than many of the surrounding areas[19], it is more likely that an offer of employment may include such a benefit. As is often the case, however, a health care benefit may be tied to full- or nearly fulltime employment, even with the tight labor market. Since the proposed project will provide access to health coverage through Medicaid, workers with disabilities who are initially unable to sustain fulltime employment can access health care coverage with the MBI until they are able to do so. Workers who can gain employer sponsored health care coverage will benefit from the wrap-around coverage of Medicaid, plus personal assistance services if needed. In this situation, MBI program costs will be reduced as a result of the employer health plan serving as primary coverage for the individual.

Quality

21. ***What is the process that participants may use to inform case managers of complaints beyond the semi-annual interview to ensure early intervention in helping persons maintain employment?***

Response: The semi-annual interviews are intended to gather data on a regular basis and provide an opportunity for each participant to express a need for additional support services, elaborate upon any problems he or she has encountered and offer constructive criticism about the program. While an individual can voice complaints at that time, the complaint process will not be limited to two occasions per year. Program participants will be given information to be able to register complaints or request additional assistance at their convenience by placing a telephone call, an email, or standard written correspondence to the MBI program administration, or through the individual's employment supports coordinator/case manager. If the individual is participating in the tiered employment requirement (due to income below the minimum earnings requirement) or if the individual has income above the target but has opted to utilize the employment supports services that are available to all participants, then the individual can contact his or her employment supports coordinator at any time to lodge the complaint. All MBI participants will be able to contact the program interviewers at any time for the same purpose. The only difference will be that the interviewers will not have regular clients, or cases, unlike the employment supports coordinators. In either case, there will be a formal process in place for the logging of complaints, investigating, taking corrective action if necessary, and responding to the participant. Should the participant be dissatisfied with the result of the complaint response, the individual will have the right of

[19] Excerpts from press release of April 28, 2004, Virginia Employment Commission, Economic Information Services Division: Virginia's 3.4 percent March 2004 unemployment rate was well below both the March 2003 Virginia jobless rate of 4.1 percent and the U.S. March 2004 unemployment rate of 6.0 percent. All eight Virginia metropolitan areas followed the statewide trend to lower unemployment rates in March. Northern Virginia, the state's largest metropolitan area, where unemployment was down from 2.2 percent in February to 2.1 percent in March, had the lowest metro area unemployment rate, as has been the case in recent months.

appeal, as described in the original waiver application submission (Quality and Evaluation section, item C, page 24).

22. ***What quality and performance measures will be used to evaluate the project (formal evaluation activities and QA and QI projects)?***

Response: The project evaluation will include both process and outcome components (i.e., both formative and summative evaluation activities). The focus of the process evaluation will be on addressing three main questions related to implementation of the project:

1. What combinations of services and supports contribute to the anticipated outcomes for participants?
2. What background experiences and characteristics of participants are related to positive outcomes?
3. What barriers exist that affect participants' ability to achieve the desired outcomes?

The focus of the outcome evaluation will be on three major issues related to the impact of the project:

1. What effect does the project intervention have on participants' employment success?
2. What effect does the project intervention have on participants' use of health care services?
3. How satisfied are participants with various aspects of the MBI program: access, ongoing service and support coordination, and the services and supports they receive?

The program will track enrollees' utilization of employment supports and other services, both through program records that will be developed and maintained by project staff, and through the periodic interviews that will be conducted with project participants. This information will enable examination of the effects of various types and intensity of services on participants' employment outcomes.

As mentioned in the response to question #1 above, data on participants' employment history and personal characteristics (such as age, race, gender, disability or disabilities, level of education) will be used to examine the impact of these various factors on participants' levels of employment success and health care utilization. Some of this information will be collected from participants as part of the enrollment process. Other information will be collected through the initial interview that will be required of all enrollees.

Information regarding barriers will be collected in several different ways. Questions regarding participants' perceptions of barriers will be included in the periodic structured interviews. As part of the ongoing assessment of project implementation, periodic focus groups will be held to explore what barriers may have arisen for project participants, as well as other issues that may affect the successful implementation of the project. These focus groups will include project participants, representatives from the various agencies that are providing employment services and supports, the project staff who are responsible for ongoing employment supports coordination, and others (including, as appropriate, project

participants' employers, advocates, members of the Medicaid Infrastructure Grant Advisory Committee, and other stakeholders).

As indicated in the response to question #1, data on participants' employment duration and earnings will be obtained from records maintained by the Virginia Employment Commission, and will include employment data both before and after enrollment in the MBI program. These data will enable the project staff to examine the impact of program participation on participants' employment experiences and earnings. Data on medical and other health care utilization, which will be obtained from Medicaid claims data maintained by DMAS, will be used to examine the effects of program participation on health care utilization. Participants' satisfaction with the program will be collected through periodic participant surveys, possibly administered in conjunction with the periodic structured interviews of participants.

The ongoing assessment of project implementation will also include examination of various readily available sources of program information: enrollment and disenrollment data, Medicaid claims data, incident reports and/or complaints. To the extent that these data sources, as well as the periodic focus groups, identify any particular ongoing concerns about the quality of Virginia's MBI program, a formal quality improvement project will be planned and implemented, using the Work Book on Improving the Quality of Home and Community Based Services and Supports (CMS, 2003) as a guide.

Quality assurance and quality improvement processes are integral parts of the Medicaid managed care programs. In accordance with 42 CFR §438.208, HMO contractors must have systems in place that ensure coordinated patient care for all enrollees and that provide particular attention to the needs of enrollees with complex, serious and/or disabling conditions. The systems, policies and procedures for the coordination and continuity of care are required to be consistent with the most recent standards of the National Committee for Quality Assurance (NCQA). QI activities must be coordinated with other performance monitoring activities, including the monitoring of enrollees' grievances and appeals and again, must reflect the most current requirements of NCQA. The Consumer Assessment of Health Plans Survey is periodically administered to Medicaid HMO enrollees and also once every waiver period to a representative sample of MEDALLION enrollees. DMAS administers a recipient helpline that receives calls regarding complaints and its enrollment broker for the managed care plans also takes calls regarding complaints. Complaint logs are regularly monitored and irregularities are addressed promptly. DMAS also contracts with an external quality review organization for additional oversight of its programs. All of the above QA and QI processes are important features of the Virginia Medicaid program. QA/QI reporting will include the MBI population and evaluation of this subset will be undertaken if appropriate.

Provider Payment

23. ***How are case management services paid for?***

Response: Case management services may be paid for in at least three different ways: on a per unit of service basis, per milestone, or per person. Given the expected variability of intensity and mix of services needed and the length of time services may be needed, it is anticipated that the most cost effective method for providing employment supports and case management services will be on a per unit or per hour basis.

The proposed MBI waiver program is intended to ensure maximum use of existing supports and services. In addition to the vocational rehabilitation and community living services available through DRS and DBVI, the individual support and advocacy services available through the Centers for Independent Living, the treatment and support services available through the local mental health service providers, the employment support services offered by local non-profit agencies, the supports available may also include customized employment services provided through the U.S. Department of Labor grant awarded to the Northern Virginia Workforce Investment Board through the One-Stops. DRS has earmarked funds to provide for employment supports coordination and case management components that may be needed outside of their standard array of support services. DMHMRSAS has identified funds to likewise support participants with serious mental illness as needed.

Who will pay for additional disability determinations for prospective participants without documentation of SSA disability?

Response: The Department of Rehabilitative Services has State general funds allocated to its budget to conduct disability determinations by their Disability Determination Services unit (DDS) for those individuals who apply for Medicaid coverage and have not yet received a determination of disability by SSA. DMAS has a contractual arrangement with the DRS to conduct determinations for the Virginia Medicaid program. It is expected that relatively few applicants for the MBI waiver will not have received a SSA determination and, therefore, existing staff will be able to absorb any additional evaluations required as a result of the new program. Furthermore, DMAS projects that the majority of applicants for the proposed MBI program will already be enrolled in other Medicaid covered groups and, therefore, were previously determined to have a disability by SSA or the DDS.

Cost Sharing

24. ***How will monthly premiums be funded if after six months of unemployment, the participant cannot find employment or if the enrollee's health prevents the individual from resuming employment?***

Response: Please see response to question #13 regarding payment of premiums. The employment supports coordinators and MBI program staff will make every effort to assist

individuals in continuing in the program. However, if individuals are unable to pay premiums or return to work, these cases will be referred to DSS for determination of eligibility under other regular Medicaid covered groups in an effort to ensure continuation of coverage when appropriate. Individuals who are not eligible for either the MBI or other Medicaid covered groups will be given assistance by MBI program staff and referred to the local BPAO to determine if other health care coverage or other needed assistance is available.

Why is the designated length of time for unemployment only six months? If the case manager determines that the participant cannot resume employment, does the case manager have the flexibility to recommend reinstatement of Medicaid benefits in less than six months?

Response: The length of six months was by consensus of the Advisory Committee's subgroup on technical design and was considered a reasonable compromise with the limited number of slots available through the proposed waiver. An expedited process will be available to re-determine eligibility and reinstate individuals to regular Medicaid covered groups in less than six months if the employment supports coordinator/case manager and the participant agree that he or she will be unable to resume employment.

Budget Neutrality Analysis

25. ***Submit without waiver projections that separate and clearly identify current law vs. hypothetical populations. Submit with-waiver budget calculations that demonstrate minimally savings of $48,000 annually.***

Response: DMAS has provided revised projections of Medicaid expenditures with and without the waiver that demonstrates cost savings will be realized by the waiver. Please see tables in APPENDIX IV (pages 39-40).

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26. ***Who is included in the budget projections on pages 18 and 20? Do cost projections include individuals not currently enrolled in Medicaid?***

Response: The revised budget tables in APPENDIX IV (pages 39-40) show the estimated costs for the waiver including the estimated 20 percent (40) waiver participants who are expected to be new to the Medicaid program. They also show, on a global basis, projected Medicaid costs with and without the waiver for individuals with disabilities.

27. ***Given that a sliding fee is reflected, clarify why annual expenditures grow while personal assistance and premium collections remain constant over the 5-year demonstration period?***

Response: The sliding fee would not affect the personal assistance estimates. The sliding fee would only affect the premium collections, which could potentially increase the level of collections if individuals earned incomes increase. DMAS, however, used a more

conservative assumption that premium collections would not significantly increase over time and calculated premiums based on the required minimum payment level. It should be noted that the minimum payment has been increased from $25.00 to $35.00 per month (see revised schedule below) since the original waiver application. The personal assistance estimates did not increase over time due to the nature of the service. Utilization per recipient for personal assistance services is not expected to substantially change from year to year for this population and the rate paid for personal care in Virginia is not adjusted except through funding initiatives in the state budget process. While future adjustments cannot be predicted, should the rate increase, the cost of providing services through the waiver will obviously increase.

Table 4
Premium Schedule

	Countable Income Per Month			
	Less than $700	$700 – $899	$900 – $1099	$1100 and above
Monthly Premium	$35.00	$45.00	$55.00	$65.00

28. ***Does the State intend to place a cap on the amount of personal assistance services enrollees may receive in order to remain within the $120,000 allocation?***

Response: The $120,000 estimate is based on average per person cost in DMAS' current Home and Community-Based Services waivers. The utilization is projected based upon the experience of Minnesota's MBI program and variability was not projected beyond the expected (constant) use by six percent of MBI participants. There is no proposal to cap the total personal assistance services expenditures in the waiver.

Funding Streams

Please address the funding questions below as they pertain to personal assistance services and case management under the proposed demonstration.

29. ***Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved State Plan. To ensure that program dollars are used only to pay for Medicaid services, we are asking the State to confirm to CMS that providers in the Medicaid Buy-In Demonstration would retain 100 percent of the payments. Would the State, through the Medicaid Buy-In Demonstration, participate in activities such as intergovernmental transfers or certified public expenditure payments, including the Federal and State share; or, would any portion of any payment returned to the State, local governmental entity, or any other intermediary organization? If the Medicaid Buy-In Demonstration would be required to return any portion of any payment, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of the amount or percentage of payments that are returned and the***

disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

Response: The State does not intend to use intergovernmental transfers or certified public expenditures to finance the state share of Medicaid payments.

30. ***Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state's share of the Medicaid payment for Medicaid Buy-In Demonstration would be funded. Please describe whether the state's share would be from appropriations from the legislature, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Please provide an estimate of total expenditures and State share amounts for the Medicaid payment. If any of the state share would be provided through the use of local funds using IGTs or CPEs, please fully describe the matching arrangement. If CPEs are used, please describe how the state verifies that the expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b).***

Response: Funding of the state share for all payments eligible for federal matching funds contemplated under this waiver (both waiver and state plan payments) will be made from general fund appropriations.

31. ***Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments would be made, please provide the total amount for each type of supplemental or enhanced payment made to the Medicaid Buy-In Demonstration.***

Response: DMAS does not contemplate making supplemental or enhanced payments.

32. ***Would any public provider receive payments (normal per diem, DRG, fee schedule, global, supplemental, enhanced, other) that in the aggregate exceed its reasonable costs of providing services? If payments exceed the cost of services, does the State recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?***

Response: Public providers would not receive payments that in the aggregate exceed its reasonable costs of providing services.

REVISIONS TO ORIGINAL SECTION 1115 WAIVER APPLICATION OF 11/07/03

Program Infrastructure

C. Describe how beneficiary choice of providers will be maintained.

(page 16)

The waiver demonstration project participants will be enrolled in ~~Virginia's Fee-For-Service Medicaid plan. This plan allows any beneficiary to seek services from any Medicaid contracted provider in the Commonwealth. Participants will not have to participate in~~ either managed care program, MEDALLION (Primary Care Case Management) or Medallion II (Health Maintenance Organization). *Enrollment in Virginia's Fee-For-Service Medicaid plan will only be the recipient's plan in the event neither MEDALLION or Medallion II is available in the community in which the participant resides, or if the participant has Medicare or medical insurance coverage other than Medicaid. As of March 2004, the managed care programs serve approximately 66 percent (15% PCCM, 51% HMO) of the Medicaid recipients in the Commonwealth. These managed care programs maintain high levels of satisfaction with the recipient population that is covered, as evidenced by recipient surveys, complaint logs, and independent third-party quality assurance reports. The Northern Virginia target area for the proposed MBI waiver is served by only one HMO, UniCare. Medicaid recipients and future MBI waiver participants may choose to obtain health coverage through this HMO or the MEDALLION Primary Care Case Management program.*

General

A. Describe the State's project, design, and target population. Included in this is the requested demonstration authority and/or waivers that the State will need for the program

(page 3, paragraph 3)

Upon approval of the waiver proposal, DMAS will begin providing MBI project information in 2004 to various public and private entities to publicize the project and begin providing enrollment information to potential participants and employers. The MIG Advisory Committee's Communication and Education Subcommittee has done considerable work in this regard and will provide significant input in this effort. ~~Enrollment in~~ *Eligibility for* the project will ~~occur~~ *be determined* at local Virginia Department of Social Services (DSS) offices, where eligibility determinations are currently done for the Virginia Medicaid program. The DSS will also be responsible for determining if individuals continue to remain eligible to participate in the project ~~and recalculate the monthly buy-in premium~~ as earnings increase. DMAS will provide training and reference materials to DSS so enrollment in the project can begin on the anticipated start date.

DSS eligibility workers will not set the premium amount charged. MBI program administration representatives will do so after countable income has been established and communicated by the DSS and a determination of eligibility has been confirmed. Enrollment will occur after payment of premium for the first month of coverage.

APPENDIX I

Support Services Available Through
Department Of Rehabilitative Services (DRS) and
Department Of Mental Health, Mental Retardation & Substance Abuse Services (DMHMRSAS)

I. DRS Community Vocational Rehabilitation Support Service Array

Core Services

Through its vocational rehabilitation (VR) program, DRS can provide eligible individuals with a broad range of services. For consumers determined eligible for the VR Program, the scope of services provided by DRS may, based on an assessment of VR service needs, include:

- Assessment for determining vocational rehabilitation needs;
- Vocational rehabilitation counseling and guidance;
- Referral and other services to secure needed services from other agencies;
- Job-related services including job search and placement assistance; job retention services, follow-up services, and follow along services;
- Vocational and other training services, including personal and vocational adjustment services, books, tools, and other training materials, except that training services at an institution of higher education are subject to comparable benefits;
- Physical and mental restoration to the extent that financial support is not readily available from a source (such as through health insurance of the consumer) or through comparable benefits;
- Maintenance for additional costs incurred while participating in the eligibility determination assessment, assessment of VR service needs, or while receiving services under an employment plan;
- Transportation to access any other service described in this section and needed by the consumer to achieve an employment outcome;
- On-the-job or other related personal assistance services needed to access any other service described in this section;
- Interpreter services provided by qualified personnel for individuals who are deaf or hard of hearing or reader services for individuals who are determined by a qualified, licensed professional to be blind;
- Occupational licenses, tools, equipment, and initial stocks and supplies;
- Technical assistance to eligible individuals pursuing self-employment or telecommuting or establishing a small business operation as an employment outcome;
- Rehabilitation technology;
- Transition services for students with disabilities;
- Supported employment services;
- Services to the consumer's family needed to assist the consumer to achieve an employment outcome;

- Specific post-employment services needed to assist the consumer to retain, regain, or advance in employment;
- Case management and support coordination matches rehabilitative needs with appropriate services.

Other Services

- Long Term Support Funding -- Extended Employment and Long Term Support Services Programs assist individuals with the most significant disabilities to maintain employment.
- Temporary Assistance to Needy Families (TANF) -- The DRS TANF Program provides vocational rehabilitation services and supports to TANF recipients who have an identified disability.
- Substance Abuse -- The Substance Abuse Program provides employment and community stability through focus on vocational development, work habits, job readiness, and employment follow-along services along with collaborative Community Services Board (CSB) clinical and social supports.
- Long Term Mentally Ill -- The Long Term Mentally Ill (LTMI) Program provides comprehensive community-based vocational rehabilitation services through specialized VR counselors.
- Brain Injury and Spinal Cord Injury -- The Brain Injury and Spinal Cord Injury Services Unit (BI/SCIS) manages multiple programs, contracts, and federal/state grants that provide brain injury services throughout the state. The BI/SCIS Unit serves as a point of contact for customers seeking general information on brain injury and spinal cord injury, or specific resources and referral information about agency services for persons with neurotrauma.
- Case Management and Support Coordination -- This service matches rehabilitative needs with appropriate services. Assists individuals with severe physical and sensory disabilities to work, to establish self-esteem, and to prevent, eliminate or reduce economic and personal dependency.
- Nursing Home Outreach – DRS provides specialized services to eligible consumers with disabilities who live in nursing facilities across Virginia. Specialized services are those services consumers need to maximize self-determination and independence that they cannot access through a nursing facility (NF) or through the standard Medicaid state plan. DRS funds Nursing Home Outreach Services through an agreement with the Department of Mental Health, Mental Retardation and Substance Abuse Services.
- Personal Assistance Services -- Personal Assistance Services (PAS) is a range of non-medical services provided by one or more persons, designed to assist a consumer with a significant physical disability with daily living activities. These consumer-directed services include transferring, bathing, eating, dressing or other physical activities.

II. DMHMRSAS Mental Health Community Support Service Array

Outpatient Services are generally provided to consumers on an hourly schedule, on an individual, group, or family basis, and usually in a clinic or similar facility or in another location, and may include diagnosis and evaluation, intake and screening, counseling, psychotherapy, behavior management, psychological testing and assessment, laboratory and other ancillary services, and medication services.

Case Management Services include: identifying and reaching out to potential consumers; assessing needs and planning services; linking the individual to services and supports; assisting the person directly to locate, develop or obtain needed services and resources; coordinating services with other providers; enhancing community integration; making collateral contacts; monitoring service delivery; and advocating for people in response to their changing needs.

Assertive Community Treatment is an outreach effort provided by a multi-disciplinary team to those people who need high levels of mental health supports and services but who, because of their psychiatric conditions, are resistant to treatment in traditional settings. Activities and services may include, but are not limited to, case management; supportive counseling; symptom management; medication administration and compliance monitoring; crisis intervention; developing individualized community supports; psychiatric assessment and other services; and teaching daily living, life, social, and communication skills. Assertive Community Treatment teams include ***Peer Counselors***.

Psychosocial Rehabilitation (Clubhouse) programs provide certain basic opportunities and services - assessment, medication education, opportunities to learn and use independent living skills and to enhance social and interpersonal skills, family support and education, vocational and educational opportunities, and advocacy - in a supportive environment in the community focusing on normalization. Psychosocial rehabilitation emphasizes strengthening the person's abilities to deal with everyday life rather than focusing on treating pathological conditions. ***Transitional Employment Services,*** typically provided to clubhouse members, involve a sequence of temporary supported placements that result in a final competitive employment placement with or without supports. Psychosocial Rehabilitation may be provided by qualified paraprofessional ***Peer Counselors*** under the supervision of a Qualified (or licensed) Mental Health Professional.

Supported Employment-Individual Placement Model programs provide work to an individual consumer placed in an integrated work setting in the community. On-going support services that may include transportation, job-site training, counseling, advocacy, and any other supports needed to achieve and to maintain the consumer in the supported placement are provided by an employment specialist, co-workers of the supported employee, or other qualified individuals. Support services are provided in accordance with the consumer's individual written rehabilitation plan.

Supportive Services are unstructured services that support individuals in their own housing arrangements. These services normally do not involve overnight care delivered by a program. However, due to the flexible nature of these services, overnight care may be provided on an hourly basis. Medicaid-funded Mental Health Support Services are most often provided in these service settings and include training and supports to enable individuals to achieve and maintain community stability and independence in the most appropriate, least restrictive environment. Mental Health Support Services may be provided by qualified paraprofessional ***Peer Counselors*** under the supervision of a Qualified (or licensed) Mental Health Professional.

Consumer-run Services provide a range of services including employment and computer skills training, warm-lines, self-help, housing alternatives, evening and weekend activities and peer support. VOCAL, a consumer-run technical assistance center, provides help to the consumer-run programs to improve services and operational management. The Virginia Human Services Training program teaches mental health consumers to become qualified paraprofessional peer counselors. The Recovery Education and Creative Healing (REACH) program trains consumers to be facilitators in Wellness Recovery Action Plan (WRAP – a federally recognized evidence based practice)

APPENDIX II

Data on Employment of People with Disabilities

Using Applicants to DRS in FY 2000 to Determine the Employment Patterns of Persons With Disabilities who Achieve Various Medicaid Waiver Earnings "Tiers"

(document is a separate .pdf file)

APPENDIX III

Medicaid Infrastructure Grant Advisory Committee

Subcommittee Membership

Technical Design Subcommittee

Daniel Mueller, Consumer
Tony Young, Endependence Center of Northern Virginia, Inc
Martha Stevens, Richmond Behavioral Health Authority
Quincy Omphlette, Henrico-Hanover-Charles City-New Kent DSB
Linda G. Broady-Myers, American Council of the Blind
Warren King, Eggleston Services
Nita Grignol/Teja Stokes, ARC of Virginia
Susan O'Mara, Virginia Commonwealth University - RRTC
Pat Lovell, Virginia Spinal Cord Injury Council
H.K. Lee, Jr., Consumer
Karen W. Brown, Brain Injury Services, Inc.
Joyce Morelli, Consumer
Michael Shank, Department of Mental Health, Mental Retardation, & Substance Abuse Services
Maureen Hollowell, Endependence Center, Inc.
Raymond Bridge, Mental Health Planning Council
Joanne Ellis, Career Support Systems, Inc.
Karen Tefelski, vaACCSES (Virginia Association of Community Rehabilitation Programs)
Ronald Lanier/Leslie Hutcheson Prince, Department for the Deaf and Hard of Hearing
Jack Quigley, Department of Medical Assistance Services
Joseph Ashley, Department of Rehabilitative Services
Hilary Malawer, Virginia Office for Protection and Advocacy

Communication/Education Subcommittee

John Toscano, The Autism Program of Virginia
Duke Storen, Department of Social Services
LaDonna Larsen, Consumer
Lisa Madron, Prince William County Community Services Board
Caryn Weir-Wiggins, Virginia Commonwealth University HIV/AIDS Center
Robbie Watts, Department of Rehabilitative Services - Disability Determination Services
Kenneth Lovern, Virginia Association for the Blind
Sharon Brent, vaACCSES / University of Iowa - Law, Health Policy & Disability Center
Mary Brown, PRS, Inc.
Gayle Harding, Disability Services Board, Northern Neck Area
Michael Cooper, Endependence Center of Northern Virginia, Inc.
Jim Taylor, Department for the Blind and Vision Impaired

Coordination of Services Subcommittee

Amy Wright, Virginia Board for People with Disabilities
Jenny McKenzie, Virginia Association of the Deaf Blind
Genni Sasnett, St. John's Community Services
Rhonda Jeter, Central Virginia Independent Living Center
Val Marsh, Virginia Alliance for the Mentally Ill
David Williams, Virginia Rehabilitation Association
Carol Webster, District 19 Community Services Board
Debe Fults, disAbility Resource Center
Patty Gilbertson, Hampton-Newport News Community Services Board
Karen Michalski-Karney, Blue Ridge Independent Living Center

APPENDIX IV

Exhibit 1
Projected Waiver Expenditures

Estimated Expenditures for the Virginia Medicaid Buy-In Program

	Recipients	Cost Per Person	Acute Care Expenditures	Personal Assistance Services	Premium Collections	Net Medical Waiver Expenditures
FY 2005	200	$7,740	$1,547,915	$120,000	($84,000)	$1,583,915
FY 2006	200	$8,359	$1,671,749	$120,000	($84,000)	$1,707,749
FY 2007	200	$9,027	$1,805,489	$120,000	($84,000)	$1,841,489
FY 2008	200	$9,750	$1,949,927	$120,000	($84,000)	$1,985,927
FY 2009	200	$10,530	$2,105,922	$120,000	($84,000)	$2,141,922

Estimated Expenditures Diverted from the Regular Medicaid Program

	Recipients Diverted From Regular Medicaid	Cost Per Person	Acute Care Expenditures	Cost Avoidance Regular Medicaid
FY 2005	160	$9,923	$1,587,606	$1,587,606
FY 2006	160	$10,716	$1,714,614	$1,714,614
FY 2007	160	$11,574	$1,851,783	$1,851,783
FY 2008	160	$12,500	$1,999,926	$1,999,926
FY 2009	160	$13,500	$2,159,920	$2,159,920

Net Savings from Medicaid Buy-In Program

	Savings
FY 2005	$3,690
FY 2006	$6,865
FY 2007	$10,295
FY 2008	$13,998
FY 2009	$17,998

1.) Estimates assume that premium collections will average $35 per waiver enrollee per month, which is the required minimum monthly premium amount.

2.) Estimates assume that approximately 80% of waiver participants would be in the regular Medicaid program if not for the Buy-In waiver.

3.) Based on data from the Massachusetts Buy-In program (see graph on following page), the cost per person in the Virginia program is projected to be 22% lower than in the regular Medicaid program.

4.) Buy-In will probably not actually start until near the end of FY 2005.

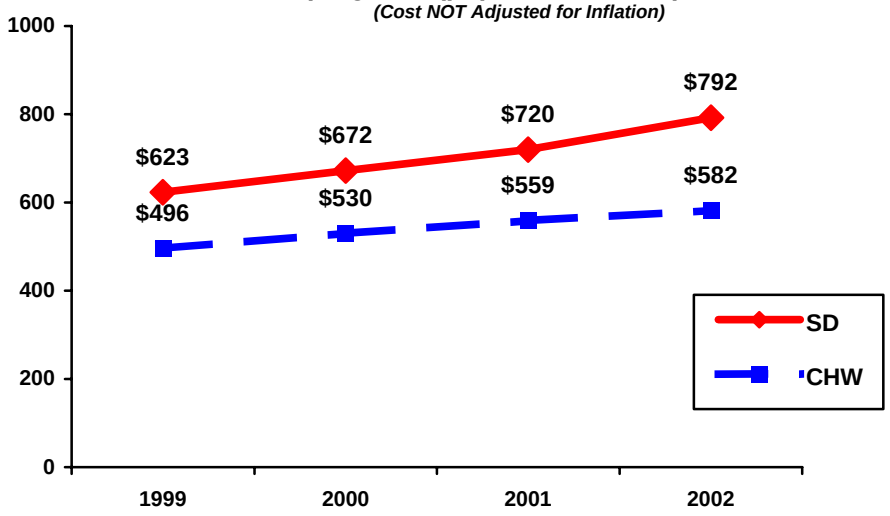
Exhibit 2
Projected Medicaid Expenditures With and Without Waiver

Virginia Medicaid Cost Experience of Disabled Recipients

	Average Monthly Disabled Enrollees	Total Expenditures Disabled Population	Cost Per Average Monthly Enrollee	Average Monthly Disabled Non-LTC Enrollees	Total Expenditures Non-LTC Enrollees	Cost Per Average Monthly Non-LTC Enrollee
FY 1999	113,032	$1,003,449,298	$8,878	75,562	$463,616,059	$6,136
FY 2000	116,578	$1,132,326,377	$9,713	75,823	$515,006,371	$6,792
FY 2001	118,229	$1,261,261,327	$10,668	75,627	$581,525,524	$7,689
FY 2002	121,660	$1,326,532,697	$10,904	78,598	$610,431,172	$7,766
FY 2003	125,297	$1,449,590,830	$11,569	81,708	$732,977,042	$8,971
Average Growth *	2.61%	9.63%	6.84%	1.97%	12.13%	9.96%
Budget Without Buy-In						
FY 2004	128,566	$1,589,155,807	$12,361	83,321	$821,929,555	$9,865
FY 2005	131,920	$1,742,193,802	$13,206	84,966	$921,645,183	$10,847
FY 2006	135,361	$1,909,969,577	$14,110	86,643	$1,033,458,206	$11,928
FY 2007	138,893	$2,093,902,401	$15,076	88,354	$1,158,836,267	$13,116
Budget Adjusted for Buy-In Savings						
FY 2006	135,401	$1,909,962,711	$14,106	86,683	$1,033,451,341	$11,922
FY 2007	138,933	$2,093,892,106	$15,071	88,394	$1,158,825,972	$13,110

* Geometric mean utilized.

Exhibit 3
PMPM cost for Massachusetts' CommonHealth Working and Standard Disabled programs (populations 18-64) 1999-2002 *
(Cost NOT Adjusted for Inflation)



* From a 2003 presentation by the Center for Health Policy and Research, UMASS Medical School; Geometric mean = 22.48% average annual per member per month difference